STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395936	A. BLDG: 00 B. WING:	05/19/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WAYNE WOODLANDS MANOR STATE LICENSE NUMBER: **065902**	**37 WOODLANDS DRIVE** **WAYMART, PA 18472**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure and Civil Rights Compliance Survey completed on May 19, 2023, it was determined that Wayne Woodlands Manor was not in compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Licensure Regulations.	F 0000		
F 0550 SS=D		F 0550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0550 SS=D	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility unable to retroactively correct alleged deficient practice for resident 11. To protect residents in similar situations, employee 6, nurse aide from staffing agency no longer works at facility. Nursing staff will be educated on the mechanical sit to stand lift and resident's personal dignity. A random audit of five residents will be conducted weekly x4, then monthly x2 by Social Services/designee, to ensure residents are being treated with	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/09/2023**

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F 0550 SS=D	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550	respect to their personal dignity and individuality when providing care. Results will be reviewed at monthly QAPI.	

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F 0550 SS=D	Continued from page 3 Based on review of grievances lodged with the facility and resident and staff interviews, it was determined that the facility failed to provide care in a manner and environment respectful of each resident's personal dignity and which enhances their quality of life as a resident of the facility as evidenced by complaints voiced by one out of 21 residents sampled (Resident 11) Findings included: An interview conducted May 20, 2023 at 12 PM with Resident 11, who was cognitively intact, alert and oriented, revealed that the resident stated that an aide who works on the 3 PM to 11 PM shift, Employee 6, a nurse aide employed by a staffing agency, will not "help her" during evening care.	F 0550		

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F 0550 SS=D	Continued from page 4 Resident 11 explained that that the resident requires the use of a mechanical lift, a sit to stand lift, (A sit to stand lift is a medical device that assists individuals with limited mobility in standing up from a seated position) for transfers. Resident 11 stated that Employee 6 told her that she (Employee 6) doesn't have the "body type" to use the sit to stand lift to transfer the resident in and out of bed and the chair. Resident 11 stated that she has to wait for another nurse aide to help her if she is out of bed in the chair. Resident 11 stated that she has a bedside commode, but when she is in bed and Employee 6 is on duty, the resident has to stay in bed and use the bedpan because Employee 6 will not transfer the resident. Resident 11 stated that she did not want Employee 6 to take care of her anymore because of	F 0550		

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F 0550 SS=D	Continued from page 5 the aide's refusal to provide the resident's care as planned. Interview with the Nursing Home Administrator and Director of Nursing on May 19, 2023, at 12 PM confirmed that Resident 11 had complained to the facility's about Employee 6's behavior towards her and approach to the resident's care. The NHA and DON confirmed that Employee 6 failed to treat Resident 11 with respect to the resident's personal dignity and individuality when providing care. 28 Pa. Code: 201.29 (j) Resident rights. 28 Pa. Code 211.12 (a)(c)(d)(5) Nursing services	F 0550		

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F 0550 SS=D	Continued from page 6	F 0550		
F 0565 SS=E		F 0565		

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F 0565 SS=E	Continued from page 7 483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 0565	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility unable to retroactively correct alleged deficient practice for Residents 11, 13, 23, 31, 47, 54 and 79. Facility will hold a Resident Council Meeting to discuss past council meeting concerns from January through April 2023, to assess if concerns are resolved or ongoing. Grievance forms will be completed as needed with follow up to each concern documented, along with resolution and resident/staff signatures. Social Services and Activities will be educated on Grievance Procedure.	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/09/2023**

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F 0565 SS=E	Continued from page 8 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 0565	Administrator/designee will audit monthly Resident Council minutes and Grievances to ensure prompt action and resolution monthly x3. Results will be reviewed at monthly QAPI.	

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F 0565 SS=E	Continued from page 9 Based on review of select facility polity, the minutes from Resident Council Meetings and grievance logs and resident and staff interviews, it was determined that the facility failed to demonstrate prompt action to resolve resident grievances raised at resident group meetings and keep the residents apprised of the status of the facility's decisions and efforts toward grievance resolution. Findings include: A review of facility policy entitled, "Resident Grievance Process" with a policy review date of May 1, 2023, revealed that the residents, families and their representatives have the right to voice grievances concerning care and treatment, behavior of staff or other residents or any concerns regarding their stay at the facility without fear of discrimination or reprisal. A staff member receiving a complaint is to complete the grievance form and if needed take immediate action to address concerns and prevent potential further violations of resident rights while the concern in being investigated. Depending on the	F 0565		

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F 0565 SS=E	Continued from page 10 circumstances of the grievance all efforts to resolve the grievance will be within 5 business days from the review date of the grievance. Upon resolution Residents or Families will be notified of the outcome by telephone or in person and if requested, in writing. All grievance decisions will include: the date the grievance was received, summary statement of the grievance, steps taken to investigate the grievance, summary of findings or conclusions, statement on whether the grievance was confirmed or not confirmed, corrective actions taken or to be taken, and date the written decision was issued. A review of the minutes from the Resident Council Meeting held January 27, 2023, revealed that 9 residents attended the meeting and 4 staff. During that meeting, the residents voiced concerns about lines to enter the dining room are too long. The facility's response was that the facility was looking into some new plans to shorten waiting time. Another resident requested that staff not play music in the halls all day long. The facility's response was that they would address the matter with staff.	F 0565		

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F 0565 SS=E	Continued from page 11 Lastly, a resident requested television volume be turned down at bedtime. The facility's response was to address the concern with staff. A review of the minutes from the Resident Council Meeting meeting held on February 24, 2023, revealed that 11 residents attended the meeting, 4 staff and the local Ombudsman. During that meeting, the residents voiced concerns about the volume of televisions being too loud at night. The facility's response was that televisions should be turned off by 11:00 PM and that the facility would discuss this matter with the roommate of the resident expressing the concern.. A review of the minutes from the Resident Council Meeting meeting held on March 31, 2023, revealed 12 residents attended the meeting and 4 staff. During that meeting the residents voiced concerns over the temperature of the resident shower room. The facility's response was that they will look into it. Another resident stated that staff should be told that they are not allowed to argue on the halls. The	F 0565		

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F 0565 SS=E	Continued from page 12 facility's response was that the matter would be addressed with staff. A review of the minutes from the Resident Council Meeting meeting held on April 27, 2023, revealed that 18 residents attended the meeting and 3 staff. During that meeting the residents voiced concerns with timely delivery of food trays, hot food served cold and that plate warmers under the plates not always provided to maintain the temperature of food. The facility's response was that this concern will be investigated. Review of the facility's log of grievances received from residents from January 2023 to the time of the survey ending May 19, 2023, revealed that the facility did not include the complaints and concerns voiced at Resident Council meetings as grievances lodged with the facility. A group meeting conducted with seven cognitively intact residents (Residents 11, 13, 23, 31, 47, 54, and 79) conducted during the survey ending May	F 0565		

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F 0565 SS=E	Continued from page 13 19, 2023, revealed that the residents in attendance stated that the complaints and concerns they bring up during Resident Council meetings "never seem to be addressed and they don't get feedback" from the facility on the status of their grievance resolution.. The residents stated that the Resident Council meetings are held monthly. The residents stated that they are still experiencing problems with timely delivery of food trays, hot food served cold and the plate warmers not consistently being utilized. Interview on May 18, 2023, at 9:50 AM with Employee 2, Social Worker, confirmed that the there was no documented evidence of the follow up to the residents' complaints. Employee 2 confirmed that the facility failed to revisit the status of the residents' complaints at subsequent resident meetings and was unable to demonstrate sufficient efforts to resolve the complaints voiced by residents during Resident Council Meetings and the residents' awareness of any actions taken by the facility to resolve their concerns.	F 0565		

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F 0565 SS=E	Continued from page 14 28 Pa. Code 201.18 (e)(1)(4) Management 28 Pa. Code 201.29 (i)(j) Resident Rights	F 0565		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 15 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility has been made aware of the deficiency for resident 26. Section N0410 was modified and resubmitted. MDS Coordinator/designee will conduct a two week look back on Significant Change MDS Assessments to ensure N0410 is accurate for anticoagulant medications during the seven-day assessment look back period. MDS staff will be educated on accurate input for section N0410, medications received during the seven-day lookback period.	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/09/2023**

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F 0641 SS=D	Continued from page 16	F 0641	MDS coordinator/designee will perform weekly audits x4 then monthly x2 on section N0410 to ensure accuracy. Results will be reviewed at monthly QAPI.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 17 Based on a review of clinical records and the Resident Assessment Instrument and staff interviews, it was determined that the facility failed to ensure that the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one resident out of 21 sampled (Residents 26). Findings include: According to the RAI User's Manual, Section N0410, "Medications Received", items in this section assesses, the number of days a resident received medications during the seven day look back period. A review of Resident 26's Significant Change MDS Assessment dated May 5,	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395936	A. BLDG: 00 B. WING:	05/19/2023

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F 0641 SS=D	Continued from page 18 2023, revealed in Section N0410 that the resident did not receive any anticoagulant medications during the seven day assessment look back period. A review of Resident 26's clinical record revealed a physician's order initially dated April 28, 2023, for Enoxaparin (an anticoagulant drug) 40 mg/0.4 ml inject once daily for 25 days. A review of the resident's April 2023 and May 2023 Medication Administration Records revealed that the resident received six doses of the anticoagulant medication over the seven day look back period prior to the Significant Change MDS Assessment of May 5, 2023. Interview with the DON (director of nursing) on May 19, 2023, at	F 0641		

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F 0641 SS=D	Continued from page 19 approximately 1:30 PM confirmed that Resident 26's MDS assessment was inaccurate with respect to medications received. 28 Pa. Code 211.5(g)(h) Clinical records 28 Pa. Code 211.12 (c) Nursing services	F 0641		
F 0642 SS=D		F 0642		

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F 0642 SS=D	Continued from page 20 483.20(h)-(j) Coordination/Certification of Assessment §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 0642	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility has been made aware of the deficiency for resident 78. Discharge MDS Assessment submitted for resident 78. MDS Coordinator will complete a two week look back period to ensure timely completion of Discharge MDS assessment. MDS staff will be educated to timely certify the completion of the Discharge MDS assessment. MDS coordinator/designee will perform weekly audits x4 then monthly x2 on Discharge MDS to ensure completed timely.	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/12/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0642 SS=D	Continued from page 21	F 0642	Results will be reviewed at monthly QAPI	

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F 0642 SS=D	Continued from page 22 Based on review of clinical records and MDS assessments and staff interview, it was determined that the facility failed to timely certify the completion of the MDS assessments of one of 21 sampled residents (Residents 78). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that the MDS Completion Date must be no later than 14 days after the Assessment Reference Date. A review of clinical record revealed	F 0642		

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F 0642 SS=D	Continued from page 23 Resident 78 was admitted to the facility on December 1, 2022, and expired and discharged from the facility on February 2, 2023. Review of the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) for Resident 15 revealed that the facility failed to complete a discharge assessment as of the survey ending May 19, 2023. Interview with the Nursing Home Administrator on May 19, 2023, at approximately 1:30 PM confirmed the above MDS assessment not certified as completed as of May 19, 2023.	F 0642		

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F 0642 SS=D	Continued from page 24 28 Pa. code 211.5(f) Clinical records 28 Pa Code 211.12 (c)(d)(3) Nursing services	F 0642		
F 0676 SS=D		F 0676		

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F 0676 SS=D	Continued from page 25 483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 0676	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility is unable to retroactively correct alleged deficient practice for Resident 29. To protect residents in similar situations, Restorative Nurse will review current residents on Restorative Therapy to ensure services were provided timely. Restorative Nurse will be educated on providing timely services necessary to maintain and prevent decline in ADL, ambulation and mobility. DON/designee will audit for timely services weekly x4, then monthly x2	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/09/2023**

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F 0676 SS=D	Continued from page 26 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by:	F 0676	on residents placed on RNP. Results will be reviewed at monthly QAPI.	

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F 0676 SS=D	Continued from page 27 Based on a review of clinical records and resident and staff interviews, it was determined the facility failed to timely provide services necessary to maintain and prevent decline in activities of daily living, ambulation and mobility, for one of 21 residents reviewed (Resident 29). Findings include: A review of the clinical record revealed that Resident 29 was admitted to the facility on January 25, 2023, with diagnoses to include fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, muscle weakness and difficulty walking. Review of the resident's Physical Therapy Discharge Summary dated March 2, 2023, revealed that Resident 29 received therapy services for January 26, 2023 through March 1, 2023, and met maximum potential with skilled services. Therapy discharge recommendations were that the resident participate in a Restorative Nursing Program (RNP)	F 0676		

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F 0676 SS=D	Continued from page 28 noting, "the prognosis to maintain current level of function (CLOF) as excellent with participation in RNP." A review of "Rehabilitation Services Restorative Nursing Referral from Physical Therapy, dated March 1, 2023, indicated that the resident's restorative plan was for standing active range of motion, hip abduction, standing marches and heel raises 3 x 10 and ambulation with RW (roller walker) up to 200 feet contact guard assist with verbal cues for RW management. A review of Resident 29's clinical record revealed that the resident was placed in the RNP program on March 20, 2023, 19 days after the referral was placed. Interview with Resident 29 on May 16, 2023, at 11:27 AM the resident stated that she received skilled physical therapy following her admission to the facility for ambulation and transfers. The resident stated that once skilled physical therapy ended, "it	F 0676		

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F 0676 SS=D	Continued from page 29 felt like it was weeks" before she began receiving a restorative nursing program. During those weeks without therapy or restorative nursing services, the resident stated that she felt her "legs weakened." Interview with Employee 1, LPN (Restorative Program Coordinator) on May 18, 2023, at 12:30 PM confirmed that the facility failed to timely provide services to maintain or improve the Resident 29's abilities to ambulate and transfer. 28 Pa. Code 211.12 (a)(c)(d)(3)(5) Nursing services	F 0676		

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F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 31 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility is unable to retroactively conduct neurological assessment for Resident 26 and 19. Document physical and pain assessment in clinical record for Resident 19. Document evidence of incident, nursing assessment and timely identification of fracture for resident 74 and complete an accurate assessment of wound for Resident 68. To protect residents in similar situations, residents who have unwitnessed falls, incidents with injury involving pain, requiring physical assessment and new admissions with wounds have the	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/09/2023**

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F 0684 SS=E	Continued from page 32	F 0684	potential to be affected by this alleged deficient practice. Facility will conduct a two week look back of unwitnessed falls and injury with pain to determine if neurological assessments were completed, if pain assessments were completed and pain addressed. Facility will conduct a two week look back on new admissions with wounds to determine if a complete and accurate assessment of wound(s) was completed. Nursing staff will be educated on nursing assessment and documentation in clinical record, fall assessment post fall, neurological assessment, pain assessment and wound assessment on new admissions. Director of Nursing/designee will review Incident Reports and follow up documentation in morning meeting 5x week for 4 weeks then monthly x2 to ensure professional nursing staff monitored, assessed, and documented.	

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F 0684 SS=E	Continued from page 33	F 0684	Results will be reviewed at monthly QAPI.	

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F 0684 SS=E	Continued from page 34 Based on review of clinical records and select incident reports and staff interviews it was determined that the facility failed to provide nursing services consistent with professional standards of quality by failing to demonstrate that licensed nurses evaluated and recorded the provision of necessary nursing care for four residents (Resident 26, 68, 74, and 19) out of 21 residents reviewed. Findings included: According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.11 (a) The register nurse assesses human responses and plans, implements and evaluates nursing care for individuals or families for whom the nurse is responsible. In carrying out this	F 0684		

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F 0684 SS=E	Continued from page 35 responsibility, the nurse performs all of following functions: (4) Carries out nursing care actions which promote, maintain, and restore the well-being of individuals (6)(b) The registered nurse is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and Subsection 21.18. (a)(5) document and maintain accurate records. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WAYNE WOODLANDS MANOR STATE LICENSE NUMBER: **065902**	**37 WOODLANDS DRIVE** **WAYMART, PA 18472**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0684 SS=E	Continued from page 36 in the planning, implementation and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: · Assessments	F 0684		

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F 0684 SS=E	Continued from page 37 · Clinical problems · Communications with other health care professionals regarding the patient · Communication with and education of the patient, family, and the patient ' s designated support person and other third parties. A review of Resident 26's clinical record revealed that the resident was admitted to the facility on January 7, 2022, with a diagnosis of Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). A nursing note dated April 24, 2023, at 10:33 PM indicated that the resident had a fall at 9:20 PM. A review of a facility incident report dated	F 0684		

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F 0684 SS=E	Continued from page 38 April 24, 2023, revealed that the resident had an unwitnessed fall and was found lying on the floor on the left side of her bed. There was no documented evidence that professional nursing staff conducted neurological assessments of the resident after the resident's unwitnessed fall. A review of the clinical record revealed Resident 19 was admitted to the facility on December 29, 2022, with a history of falls at home, one with a fractured hip prior to her admission to the facility. The resident was admitted for post surgery therapy services and had diagnoses of chronic kidney disease and difficulty walking. The resident's admission MDS	F 0684		

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F 0684 SS=E	Continued from page 39 assessment revealed her to be moderately, cognitively impaired and required maximum assistance of staff for activities of daily living, including transfers and toileting. A care plan dated December 29, 2022 for the resident's risk for falls due to a history of falls with injury, revealed planned interventions to apply a bed alarm, sensor alarm pad to wheelchair, rear antiptippers and anti roll back brakes on the wheelchair and a bed level bathroom door alarm. A review of a facility incident report dated February 18, 2023, at 3 PM revealed that Resident 19 sustained an unwitnessed fall in her bathroom. Staff found the resident lying on her back, with her feet facing the doorway, her head and torso were under	F 0684		

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F 0684 SS=E	Continued from page 40 the sink, and the wheelchair next to her, facing the toilet. According to the report, an RN assessment was completed. The resident had complaints of pain with range of movement to left hip upon straightening. There was no nursing assessment documented in the resident's clinical record, only the notation on the incident report that an RN assessment was conducted. Nursing documentation dated February 18, 2023, at 5 PM revealed that Resident 19 sustained fall and a skin tear to her left lower extremity and a x-ray was ordered and completed. Nursing documentation dated February 18, 2023, at 9:26 PM revealed that	F 0684		

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F 0684 SS=E	Continued from page 41 irregularities were noted on the x-ray films and Resident 19 continued complain of pain. The resident was transferred to the hospital at the request of the resident's family. A nurses note dated February 19, 2023, at 05:45 A.M., revealed that the resident was admitted to the hospital with a left hip fracture. There was no documented evidence that professional nursing staff had recorded the results of the resident's physical assessment after the fall in the resident's clinical record and that licensed and professional nursing staff had consistently assessed the resident's pain after the fall through the time of the resident's transfer and admission to the hospital.	F 0684		

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F 0684 SS=E	Continued from page 42 During an interview on May 19, 2023, at approximately 12:30 PM, the Nursing Home Administrator verified that professional nursing staff failed to conduct neurological assessments after unwitnessed fall consistent with professional standards of practice and failed to document the results of physical, neurological and pain assessments in the resident's clinical record. A review of Resident 74's clinical record revealed that the resident was admitted to the facility on October 6, 2022, with diagnoses of dementia(a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), anxiety and insomnia. A review of facility documentation dated	F 0684		

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F 0684 SS=E	Continued from page 43 April 6, 2023, Resident 74 "banged her leg on the bed frame during a transfer on April 6, 2023 at 0400" (4:00 AM). A witness statement provided by Employee 7, a nurse aide, indicated that at 4:00 AM the aide was assisting Resident 74 back to bed. While Employee 7 was fixing the sheets the resident kicked her leg up and hit bed frame. Employee 7's statement indicated that after the nurse (Employee 8, LPN) and the nurse aide put the resident back in bed the resident's leg was checked and a small red mark was observed on her leg. Employee 8, LPN, witness statement indicated that she helped Employee 7 put the resident to bed and as they were putting resident into bed Resident 74 bumped her right shin and there was a red	F 0684		

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F 0684 SS=E	Continued from page 44 mark on her shin. A review of Resident 74's clinical record failed to reveal documented evidence of the incident on April 6, 2023, at 4:00 AM or that a nursing assessment was completed. A nursing progress note dated April 6, 2023, at 14:44 (2:44 PM) noted "Resident climbing the AM. Aide called this nurse into room at 0730. Resident noted with redness on right leg. Leg warm to touch, no swelling noted. An abrasion measuring approx. 1.3 cm x 0.7 cm. Resident uncooperative with measurement. Supervisor aware. Resident yelled 'ouch' when leg touched. Tylenol given with effect." There was no further nursing	F 0684		

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F 0684 SS=E	Continued from page 45 documentation regarding assessment and monitoring of the resident's legs after the incident and observed injury. A review of a facility incident report dated April 7, 2023, at 12:39 PM, indicated "resident in bed with new onset RLE (right lower extremity) at lower skin and ankle area redness, warmth, swelling and pain with palpation and movement , no known fall or trauma. Winged mattress in place." A progress note dated April 7, 2023, at 1600 (4:00 PM) revealed "resident with new onset right lower leg/ankle redness, warmth, swelling, very painful with touch or movement, no known trauma or fall, md called new order received for testing. X-ray of right foot ankle done. Results called to MD. Order received to transfer	F 0684		

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F 0684 SS=E	Continued from page 46 to emergency room for evaluation." The results of an x-ray report date of exam listed as April 7, 2023 at 2:19 PM revealed that Resident 74 had and x-ray of the right foot and right ankle. The impression noted was that the resident had a "slightly separated and nonunion and relatively acute oblique fracture of the distal right fibula, with soft tissue swelling over the lateral malleolus suggesting acute morphology". Interview with the Nursing Home Administrator on May 19, 2023 at 1:00 PM confirmed that there was a lack of documented evidence that licensed and professional nursing staff had consistently monitored and assessed the resident's leg in response to observed injuries, the red and abraded areas and complaints of pain,	F 0684		

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F 0684 SS=E	Continued from page 47 to timely identify and act upon the resident's fracture. A review of Resident 68's clinical record revealed that the resident was admitted to the facility on March 13, 2023, with diagnoses which included acquired absence of right leg below the knee, and peripheral vascular disease. A review of Resident 68's admission Minimum Data Set Assessment dated March 20, 2023, revealed that the resident had a Stage III pressure injury and venous and arterial wounds. A facility form entitled, "Admit/Readmit Screener- V-4" dated March 13, 2023, revealed that the resident was identified with three (3) vascular wounds on her left upper leg and one (1) pressure injury on	F 0684		

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F 0684 SS=E	Continued from page 48 her right below the knee amputation site. This admission screen failed to reflect a complete nursing assessment of the condition of surrounding skin, tunneling or undermining, and drainage (amount, odor, type). Interview with the Director of Nursing on May 19, 2023 at 11:00 AM, confirmed the facility's licensed and professional nursing staff failed to record complete and accurate assessment of the resident's wounds. 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing Services 28 Pa. Code 211.5 (f)(g)(h) Clinical Records	F 0684		

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F 0684 SS=E	Continued from page 49	F 0684		
F 0689 SS=G		F 0689		

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F 0689 SS=G	Continued from page 50 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility is unable to retroactively correct alleged deficient practice for Resident 19. To protect residents in similar situations, an audit will be conducted of wheelchair alarms to ensure proper function and bathroom door alarms will be assessed for proper placement. Nursing staff will be educated on safety and fall prevention measures to include resident functioning wheelchair alarms and appropriately positioned door alarms. Nursing Supervisor/designee will	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/09/2023**

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F 0689 SS=G	Continued from page 51	F 0689	audit five random wheelchair alarms and door alarms to ensure that planned safety and fall prevention measures are consistently implemented, weekly x4, 2 x month x 1 then monthly x 1. Results will be reviewed at monthly QAPI. Facility is unable to retroactively correct alleged deficient practice for Resident 19. To protect residents in similar	

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F 0689 SS=G	Continued from page 52	F 0689	situations, an audit will be conducted of wheelchair alarms to ensure proper function and bathroom door alarms will be assessed for proper placement. Nursing staff will be educated on safety and fall prevention measures to include resident functioning wheelchair alarms and appropriately positioned door alarms. Nursing Supervisor/designee will audit five random wheelchair alarms and door alarms to ensure that planned safety and fall prevention measures are consistently implemented, weekly x4, 2 x month x 1 then monthly x 1. Results will be reviewed at monthly QAPI.	

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F 0689 SS=G	Continued from page 53 [redacted]	F 0689		
F 0690 SS=D		F 0690		

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F 0690 SS=D	Continued from page 54 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility unable to retroactively correct deficient practice for Resident 19. Resident 19 was placed on a 72-hour Bowel and Bladder Monitor May 10th, 2023 and a toileting plan was initiated. To protect residents in similar situations, residents who have attempted to self-toilet and fallen in past two weeks will be audited to assess if a Bowel and Bladder Monitor was completed. Nursing staff will be educated on Bowel and Bladder program, falls with self-toileting and need for	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/09/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395936	A. BLDG: __00_____ B. WING: _____	05/19/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WAYNE WOODLANDS MANOR STATE LICENSE NUMBER: **065902**	**37 WOODLANDS DRIVE WAYMART, PA 18472**

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F 0690 SS=D	Continued from page 55 This REQUIREMENT is not met as evidenced by:	F 0690	follow up with 72-hour Bowel and Bladder Monitor. B&B Nurse/designee will audit residents who have fallen with self-toileting to ensure 72-hour Bowel and Bladder Monitor initiated and to develop an individualized plan to meet toileting needs, weekly x4, then monthly x2. Results will be reviewed at monthly QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395936	A. BLDG: 00 B. WING:	05/19/2023

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F 0690 SS=D	Continued from page 56 Based on review of clinical records and select facility policy, resident and staff interview and observations, it was determined that the facility failed to ensure that residents who are continent of bowel and bladder are provided necessary services to maintain continence to the extent possible and prevent further decline in continence for one resident out of 21 sampled (Residents 19). Findings include: Review of the facility policy entitled Bowel and Bladder Policy that was last reviewed by the facility May 1, 2023, revealed that it is the policy of the facility to promote and maintain the highest level of continence for all residents where appropriate.	F 0690		

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F 0690 SS=D	Continued from page 57 The procedure were noted as: -Licensed staff will perform a detailed evaluation on all admissions, readmissions and significant changes. -detailed evaluation form to be completed 3-5 days after admission and re-admission, then an assessment of the bowel and bladder status will be formulated by the program coordinator. If conclusion determines appropriateness for scheduled toileting plan, an individualized continence plan of care will be instituted. These continence plans will be specific to each resident with scheduled hours of toileting. -Residents not requiring a plan or schedule, will be either continent, or incontinent without awareness, urges, refusal of scheduled plan or has had previous attempt that have been	F 0690		

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F 0690 SS=D	Continued from page 58 unsuccessful. These incontinent residents shell be placed on a check and change schedule. Continent residents will continue to be monitored for any changes of same. -The program coordinator will perform quarterly review of each scheduled bowel and bladder program to assess effectiveness and adjust accordingly. -The nurse aide will be made aware of each resident on a scheduled continence plan by the coordinator. Documentation of timed toileting will be done through the scheduled continence plan, in the kiosk. A review of the clinical record revealed that Resident 19 was admitted to the facility on December 29, 2022, for post surgery therapy after a fall at home and a fractured hip. The resident's diagnoses included chronic kidney disease and	F 0690		

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F 0690 SS=D	Continued from page 59 difficulty walking. The resident's baseline care plan, initiated December 29, 2022, revealed that Resident 19 was required extensive assist of one staff for toileting. The resident's initial care plan did not include any further interventions related to the resident's toileting needs. A review of the resident's activities of daily living records for bowel and bladder activity dated dated January 2023 through the survey ending May 19, 2023, revealed inconsistent documentation, with multiple shifts of nursing duty during which staff failed to record the resident's bladder and bowel activity. An admission MDS Assessment January 2, 2023, (Minimum Data Set - a federally	F 0690		

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F 0690 SS=D	Continued from page 60 mandated standardized assessment conducted at specific intervals to plan resident care) revealed that the resident was moderately cognitively impaired and required maximum assistance of staff with activities of daily living, including transfers and toileting. A review of a fall investigation report dated January 16, 2023, at 10:07 PM revealed that at 3:15 PM staff found Resident 19 lying on floor of the resident's room, on her left side, between her recliner chair and bed. The resident's alarm was sounding to alert staff to the resident's fall. Staff entered into the room and heard resident yelling out for help. A review of a nursing progress, type bowel and bladder note, dated January 26, 2023 at 1:22 P.M., revealed that the	F 0690		

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F 0690 SS=D	Continued from page 61 resident was frequently incontinent of urine with infrequent episodes of bladder continence and was continent of bowel. The resident was noted to be unaware of bladder urges. The resident was placed on an every two hour check and change program according to facility protocol and it was noted to be appropriate for the resident at this time A review of a fall investigation report dated February 18, 2023, at 3 PM revealed that Resident 19 had an unwitnessed fall in the bathroom of her room. Staff found the resident lying on her back with her feet facing the bathroom doorway, her head and torso were under the sink, and her wheelchair was next to her facing the toilet. The resident had been incontinent of urine at the time of the fall. The report noted that staff had last toileted the resident at 1:30 PM.	F 0690		

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WAYNE WOODLANDS MANOR STATE LICENSE NUMBER: 065902	37 WOODLANDS DRIVE WAYMART, PA 18472

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F 0690 SS=D	Continued from page 62 There was no bladder assessment completed in response to the resident's fall while attempting to self-toilet in the bathroom and resulting episode of urinary incontinence. There was no documented evidence that the facility had reviewed and revised the resident's care plan for toileting needs in an effort to prevent further decline in bladder function and in response to a fall related to self-toileting. During an interview on May 18, 2023, at 8 PM Resident 19 stated that recently she can use the call bell to notify staff she needed to use the bathroom. Resident 19 stated that she is incontinent some of the time and does, at times, feels the urge to urinate. She stated that she does often wait for staff to answer the call bell for	F 0690		

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F 0690 SS=D	Continued from page 63 long periods of time, especially on the 3 PM to 11 PM shift and as a result attempts to toilet herself because she cannot wait any longer for staff assistance. Interview with the Director of Nursing (DON) on March 19, 2023, at 9 AM, confirmed that the facility failed to develop an individualized plan to meet the resident's toileting needs in a timely manner to maintain continence and prevent attempts at self-toileting. Refer F689 28 Pa. Code 211.10(a)(c)(d) Resident care policies 28 Pa. Code: 211.12 (a)(d)(5) Nursing Services	F 0690		

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F 0690 SS=D	Continued from page 64 28 Pa. Code 211.11(d) Resident care plan	F 0690		
F 0697 SS=E		F 0697		

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F 0697 SS=E	Continued from page 65 483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0697	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility cannot retroactively correct deficient practice for Resident 73 and 74. To protect residents in similar situations, a two week look back for residents receiving PRN Hydrocodone will be conducted to ensure non pharmacological interventions were attempted to alleviate pain prior to administration of pain medication. A two week look back for residents with mild pain will be assessed for significant change in level of pain, MD notification and if Tylenol was given for pain outside of pain scale parameters.	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/13/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0697 SS=E	Continued from page 66	F 0697	Licensed nursing staff will be educated on non-pharmacological interventions prior to administering PRN opioid medication and notifying Physician with any significant change in level of pain for PRN Tylenol medication. Licensed nursing staff will be educated in notifying physician if resident pain is outside of the pain scale for ordered pain medication. DON/designee will conduct five random audits on PRN pain medication to ensure non-pharmacological interventions were attempted and proved ineffective prior to administering PRN opioid. MD notification if there was significant change in level of pain, and pain scale followed correctly for PRN medication, weekly x4, then monthly x2. Results will be reviewed at monthly QAPI.	

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F 0697 SS=E	Continued from page 67 Based on clinical record and select facility policy review and staff interview, it was determined that the facility failed to provide effective pain management and administer pain medication as prescribed by the physician and failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of a pain medication prescribed on an as needed basis for two of 21 residents sampled (Resident 73 and Resident 74). Findings include: Review of a facility policy entitled "Pain Assessment and Management" that was reviewed by the facility on May 1, 2023, revealed that staff should assess pain by using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. Additionally, the policy indicated the facility should report to physcian or practitioner if significant changes in the level of the resident's pain. Non-pharmacologic interventions may be appropriate alone or in conjunction with medications. Some	F 0697		

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F 0697 SS=E	Continued from page 68 non-pharmacological interventions include repositioning, cool or warm compresses, massage, and/or range of motion exercises. Administer medication regimen as ordered and staff are to carefully document the results of the interventions. Review of Resident 73's clinical record revealed that she was admitted to the facility on October 13, 2022, with diagnoses to have included a right lower extremity amputation [is the loss or removal of a body part such as a finger, toe, hand, foot, arm, or leg] and peripheral vascular disease [(PVD) is a slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel that results in pain]. Review of Resident 73's plan of care for pain that was initiated on October 14, 2022, indicated that the resident had a potential for pain related to right lower extremity amputation with arterial occlusion. The planned interventions were to administer pain medications per physician orders, offer non-pharmacological interventions prior to	F 0697		

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F 0697 SS=E	Continued from page 69 medication administration, and to notify the physician if interventions are unsuccessful of if complaint is a significant change from residents past experience of pain. Review of physician's orders dated March 27, 2023, at 12:00 AM, revealed an order for Hydroco/APAP [combination medication is used to relieve moderate to severe pain that contains an opioid pain reliever (hydrocodone) and a non-opioid pain reliever (acetaminophen)] tablet 325 mg one tablet by mouth every 6-hours PRN (as needed) for moderate pain. Review of Resident 73's Medication Administration Record (MAR) for April 2023 revealed that the opioid pain medication was given on the following dates: on April 3, 2023, at 4:28 PM, for a reported pain level of 4; on April 18, 2023, at 8:19 PM, for a reported pain level of 5; on April 19, 2023, at 4:30 PM, for a reported pain level of 5; on April 24, 2023, at 5:21 PM, for a reported pain level of 4; and on April 28, 2023, at 5:00 PM, for a reported	F 0697		

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F 0697 SS=E	Continued from page 70 pain level of 4. The facility failed to provide evidence that non-pharmacological interventions were consistently attempted, and proved ineffective, prior to administering a prn opioid pain medication for moderate pain. Review of Resident 73's May 2023 MAR through survey ending May 19, 2023, revealed that the opioid pain medication was administered on the following dates: on May 4, 2023, at 8:08 PM, for a reported pain level at 4; on May 10, 2023, at 5:54 PM, for a reported pain level of 4; on May 11, 2023, at 5:02 PM, for a reported pain level of 4; on May 12, 2023, at 7:55 PM, for a reported pain level of 4; on May 14, 2023, at 5:00 PM, for a reported pain level of 7; on May 15, 2023, at 7:51 PM, for a reported pain level of 4; on May 16, 2023, at 4:51 PM, for a reported pain level of 5; on May 17, 2023, at 4:38 PM, for a reported pain level of 5; and on May 18, 2023, at 1:12 PM, for a reported pain level of 7.	F 0697		

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F 0697 SS=E	Continued from page 71 The facility failed to provide consistent documented evidence that non-pharmacological interventions were attempted prior to administering an prn opioid pain medication for moderate pain. Review of Resident 74's clinical record revealed that she was admitted to the facility on October 6, 2022, with diagnoses to have included dementia, anxiety and insomnia. Resident 74 had a physician order dated October 6, 2022, at 1445 (2:45 PM) , for a non-opioid pain reliever (acetaminophen)] tablet 325 mg two tablets by mouth every 4-hours PRN (as needed) for mild pain, scale 1-2. Review of Resident 74's April 2023 Medication Administration Record revealed staff administered Acetaminophen on April 7, 2023 at 0930 (9:30 AM) and 1341 (1:41 PM) for a pain level of 10. Review of Resident 74's clinical record failed to	F 0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395936	A. BLDG: 00 B. WING:	05/19/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WAYNE WOODLANDS MANOR STATE LICENSE NUMBER: **065902**	**37 WOODLANDS DRIVE** **WAYMART, PA 18472**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0697 SS=E	Continued from page 72 reveal the physician/practitioner was notified, as per policy due to the significant change in the level of pain expressed by Resident 74 on April 7, 2023. Interview with the Director of Nursing (DON) on May 19, 2023, at 11:30 AM, revealed that the facility used a verbal pain scale of 1 through 10, but did not use a specific standardized tool to assess pain. Further interview with the DON confirmed that there was no evidence that non-pharmacological interventions were consistently attempted and proved ineffective, prior to administering prn pain medication and facility failed to follow physican orders for the administration of pain medication prescribed for mild pain. 28 Pa. Code 211.5(f)(g) Clinical records 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing Services 28 Pa. Code 211.11 (d)(e) Resident care plan	F 0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395936	A. BLDG: __00_____ B. WING: _____	05/19/2023

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F 0697 SS=E	Continued from page 73	F 0697		
F 0699 SS=D		F 0699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0699 SS=D	Continued from page 74 483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by:	F 0699	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Resident 76s Care Plan for Post Traumatic Stress Disorder (PTSD) was updated to identify symptoms and triggers related to his diagnosis, and interventions to meet residents needs to minimize triggers. To protect residents in similar situations, residents with PTSD care plans will be reviewed and updated to reflect symptoms, triggers and interventions for minimizing re-traumatization. Nursing staff will be educated on Trauma Informed Care, PTSD care plans, resident experiences and preferences to eliminate or mitigate	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/09/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0699 SS=D	Continued from page 75	F 0699	triggers that may cause re-traumatization. Social services/designee will audit new admissions to ensure an individualized person-centered plan is addressed for diagnosis of PTSD, weekly x4 then monthly x2. Results will be reviewed at monthly QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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WAYNE WOODLANDS MANOR STATE LICENSE NUMBER: **065902**	**37 WOODLANDS DRIVE WAYMART, PA 18472**

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F 0699 SS=D	Continued from page 76 Based on a review of clinical records and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered plan to provide trauma informed care to a resident with a diagnosis of Post-Traumatic Stress Disorder for one out of 21 residents reviewed (Resident 76). Findings include: A review of the clinical record revealed that Resident 76 was admitted to the facility on December 2, 2022, with diagnoses that included Post Traumatic Stress Disorder (PTSD). The resident's current care plan, in effect at the time of review ending May 19, 2023, did not identify the resident PTSD	F 0699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395936	A. BLDG: 00 B. WING:	05/19/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WAYNE WOODLANDS MANOR STATE LICENSE NUMBER: 065902	37 WOODLANDS DRIVE WAYMART, PA 18472

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0699 SS=D	Continued from page 77 symptoms or triggers related to this diagnosis and resident specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization. The facility failed to develop and implement an individualized person-centered plan to address, this resident's diagnosis of PTSD according to standards of practice to promote the resident's emotional well-being and safety. Interview with the Nursing Home Administrator on May 19, 2023, at approximately 1:30 PM, confirmed the facility was unable to demonstrate that the facility provided culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and	F 0699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395936	A. BLDG: __00_____ B. WING: _____	05/19/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0699 SS=D	Continued from page 78 preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. 28 Pa Code 211.12 (a)(d)(3)(5) Nursing services 28 Pa Code 211.11(d) Resident care plan 28 Pa. Code 211.16(a) Social Services	F 0699		
F 0755 SS=E		F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=E	Continued from page 79 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility is unable to retroactively correct alleged deficient practice for Resident 19 and 86. Residents were not negatively affected by alleged deficient practice. To protect residents in similar situations, Oxycodone and Roxanol sign out sheets and medication administration records will be reviewed for accuracy over a two week look back period. Licensed nurses will be educated on signing the controlled drug sign out sheet for removal of opioid medication and then documenting	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/09/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=E	Continued from page 80 This REQUIREMENT is not met as evidenced by:	F 0755	on the medication administration record that it was administered. Director of Nursing/designee will audit Oxycodone and Roxanol sign out sheets and medication administration record for accuracy weekly x4 then monthly x2. Results will be reviewed at monthly QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=E	Continued from page 81 Based on review of controlled drug records and staff interview, it was determined that the facility failed to implement procedures to promote accurate records of controlled drug administration to two of 21 residents sampled (Resident 19 and 86) . Finding include: A review of the clinical record revealed that Resident 19 had a physician orders dated March 6, 2023, for Oxycodone 10 mg, one by mouth every 4 hours as needed for moderate pain. A review of a controlled drug sign out record for Oxycodone 10 mg tabs indicated that on March 6, 2023, 30 tablets were received at the facility for administration to the resident.	F 0755		

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F 0755 SS=E	Continued from page 82 Further review of the controlled drug sign out sheet for the Oxycodone 10 mg tabs noted that on the following dates the medication licensed nursing staff signed the record for removal of a dose of the opioid pain medication for administration to Resident 19: March 9, 2023 at 10:50 P.M. March 10, 2023 at 8:40 A.M. March 14, 2023 at 11:30 A.M. March 15, 2023 at 5:30 A.M. March 22, 2023 at 9:30 A.M. March 24, 2023 at 10 A.M. A review of a March 2023 Medication Administration Record (MAR) revealed no documented evidence that Oxycodone 10 mg was adminstered to the resident on the above dates and times.	F 0755		

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F 0755 SS=E	Continued from page 83 A review of the clinical record revealed that Resident 86 had a physician order dated March 1, 2023, for Roxanol 20 mg/ml, every 4 hours give 5 mg (0.25 ml) every 6 hours, sublingually(under the tongue) around the clock and every 3 hours as needed for pain. A review of a controlled drug sign out record for Roxanol 20 mg/ml indicated that on March 1, 2023, 30 mls were received at the facility for administration to the resident. Further review of the controlled drug sign out sheet for the Roxanol 20 mg/ml solution noted that on the following dates licensed nursing staff signed the record for removal of the dose of the Roxanol to administer to Resident 86:	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=E	Continued from page 84 March 2, 2023 at 12 A.M. March 2, 2023 at 6 A.M. However, a review of the resident's March MAR revealed no documented evidence the the above two doses had been adminstered to the resident. During an interview, May 19, 2023, at approximately 1 PM the Director of Nursing confirmed the inconsistencies in documentation between the controlled drug sign out records and the Medication administration record. 28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=E	Continued from page 85 28 Pa Code 211.9(a)(1)(k)Pharmacy services. 28 Pa Code 211.5(f)(g)(h) Clinical records	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=E	Continued from page 86	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=E	Continued from page 87	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=E	Continued from page 88	F 0755		
F 0757 SS=E		F 0757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0757 SS=E	Continued from page 89 483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 0757	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Resident 33 continues taking Nitrofur Mac medication daily per MD order. Physician to re-evaluate. To protect residents in similar situations, residents who are on a daily dose of antibiotic for urinary tract infection will be assessed for individual specific clinical rationale as to the benefits to the resident to support the continued use. Licensed nurses and facility Physicians will be educated on the specific clinical rationale for ongoing daily use of antibiotic for urinary tract infection.	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/12/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0757 SS=E	Continued from page 90	F 0757	Director of Nursing/designee will audit residents on continued use of daily antibiotic therapy for urinary tract infection for individual specific clinical rationale weekly x4, then monthly x2. Results will be reviewed at monthly QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395936	A. BLDG: __00_____ B. WING: _____	05/19/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WAYNE WOODLANDS MANOR STATE LICENSE NUMBER: **065902**	**37 WOODLANDS DRIVE** **WAYMART, PA 18472**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0757 SS=E	Continued from page 91 Based on a review of clinical records and staff interviews it was determined that the facility failed to ensure that a resident's drug regimen was free of unnecessary antibiotic drugs for one of 21 residents sampled (Resident 33). Findings included: A review of Resident 33's clinical record revealed a physician order dated November 18, 2020 for Nitrofur Mac cap (an antibiotic medication) 50 mg, take one capsule by mouth at bedtime for urinary tract infection. A review of the resident's medication administration record for the months of November 2020, through the present date of survey ending May 19, 2023, revealed that the resident received a daily dose of	F 0757		

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F 0757 SS=E	Continued from page 92 the antibiotic. A review of a Pharmacy to Physician medication assessment recommendation dated April 17, 2023 revealed that the pharmacist identified that "{Resident 33} is currently receiving Nitrofurantoin 50 mg, by mouth, daily at bedtime for Urinary tract infection prophylaxis (action taken to prevent disease, especially by specified means or against a specified disease). Request your consideration for discontinuing this medication. If you feel that its use is appropriate, request documentation of your risk vs benefit assessment on this form." The Physician response was noted as "Supervised usage of antibiotics is noted. Benefits outweighs risks. No change in medication."	F 0757		

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F 0757 SS=E	Continued from page 93 However the physician did not include the individual specific clinical rationale, as to the benefits to the resident to support the continued use of the antibiotic medication for Resident 33. During an interview May 18, 2023 at approximately 11 AM, the Director of Nursing confirmed the lack of current physician clinical documentation to support the continued use of the antibiotic medication. Refer F881 28 Pa. Code 211.12 (a)(c)(1)(3)(5) Nursing services 28 Pa. Code 211.9(a)(1) Pharmacy services	F 0757		

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F 0757 SS=E	Continued from page 94 28 Pa. Code 211.2 (a) Physician services	F 0757		
F 0801 SS=F		F 0801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0801 SS=F	Continued from page 95 483.60(a)(1)(2) Qualified Dietary Staff §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered	F 0801	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility cannot retroactively correct deficient practice. Residents were not negatively affected by deficient practice. Facility hired a full-time Dietitian with start date of June 5th, 2023. Facility also hired a full-time CDM with start date of June 26th, 2023. Management will be educated on Federal Regulation for Dietary Staffing and qualifications. Administrator will monitor Dietary Staffing monthly x3. Results will be reviewed at monthly	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/09/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0801 SS=F	Continued from page 96 dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State	F 0801	QAPI.	

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F 0801 SS=F	Continued from page 97 requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by:	F 0801		

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F 0801 SS=F	Continued from page 98 Based on staff interview and a review of employee personnel files and credentials, it was determined that the facility failed to employ a full-time qualified dietary services supervisor in the absence of a full-time qualified dietitian. Findings include: Interview with the facility's Dietary Manager on May 16, 2023, at approximately 9:03 AM, revealed that he became the dietary manager in January 2023, but did not possess a CDM certificate or regulatory required qualifications to serve as the director of food and nutrition services. Further interview with the Dietary Manager revealed that the full-time Registered Dietitian (RD) resigned and that the last date she worked on-site was April 14, 2023. The RD agreed to work remotely (not on-site) until the new full-time RD started, but provided no onsite visits. Interview with the Nursing Home Administrator	F 0801		

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F 0801 SS=F	Continued from page 99 (NHA) on May 17, 2023, at 1:15 PM, confirmed that the facility's the current dietary manager does not possess all the regulatory requirements for a qualified dietary services supervisor/manager and that the facility does not provide the services of a full-time qualified dietitian. 28 Pa. Code 211.6 (c)(d) Dietary services. 28 Pa Code 201.18 (e)(1)(6) Management.	F 0801		
F 0802 SS=F		F 0802		

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F 0802 SS=F	Continued from page 100 483.60(a)(3)(b) Sufficient Dietary Support Personnel §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by:	F 0802	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility unable to retroactively correct alleged deficient practice for residents 11, 13, 23, 31, 47, 54 and 79. To protect residents in similar situations, facility will conduct a two week look back period on dietary staffing schedules, and a four week look back period on dietary staff hired. Facility continues to advertise and hire dietary staff. Dietary to notify Administrator if assistance is required in kitchen. Dining room meal service has been opened for breakfast, lunch and supper to allow residents to dine in the main dining room at meals.	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/12/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0802 SS=F	Continued from page 101	F 0802	Dietary Manager will be educated on staffing ratios for dietary, following scheduled times for meal delivery, ensuring dish room activities start timely and hot food delivered hot on plate warmers and cold food delivered cold. Administrator/designee will monitor staffing ratios and delivery of meal carts weekly x4 then monthly x2 to ensure compliance. Results will be reviewed at monthly QAPI.	

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F 0802 SS=F	Continued from page 102 Based on observation, resident and staff interviews, and review of dietary staff schedules, the facility's meal service schedule, and the minutes from Resident Food Council meetings it was determined that the facility failed to consistently maintain sufficient staffing in the dietary department to effectively and efficiently carry out the functions of the food and nutrition service department. Findings include: During interviews with seven cognitively intact residents (Residents 11, 13, 23, 31, 47, 54, and 79) conducted during the survey ending May 19, 2023, the residents voiced complaints that the their meals are delivered late, the hot food is served cold and plate warmers not consistently being utilized to maintain the temperature of their meals. Review of the minutes from the facility's Food Council Meeting dated March 30, 2023, revealed that residents in attendance complained that their meals were still being served later than scheduled.	F 0802		

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F 0802 SS=F	Continued from page 103 The facility's census was 82 residents during the week of April 1, 2023. Review of the facility's dietary staffing revealed that on Saturday April 1, 2023, and Sunday, April 2, 2023, at the breakfast meal that there were only two dietary employees on duty. On April 8, 2023, there were two staff scheduled for breakfast, however one called off, leaving only one dietary employee. On Saturday April 9, 2023, there were three dietary staff scheduled for the dinner meal, but one employee called off and leaving only two dietary staff members on duty for dinner meal service, one of whom was the dietary manager. The schedules also revealed occassions that there were only two dietary employees on duty that resulted in the closure of main resident dining room. Review of the facility's document titled "Times Meals Arrive at Units" revealed that lunch tray line started in the kitchen at 11:10 AM and trays were expected to arrive on the units as follows: at 11:20 AM Cart 1 - Green Hall, at 11:20 AM Cart 2 -	F 0802		

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F 0802 SS=F	Continued from page 104 Mauve Hall, at 11:45 AM Cart 3 - Blue Hall, at 11:50 AM Cart 4 - Peach Dining Room, and at 12:00 PM Cart 5 - Peach Hall. Observation of meal delivery on the Green Hall on May 16, 2023, at 11:35 AM, revealed that the lunch meal cart did not arrive to the hall until 11:45 AM and the scheduled mealtime posted was at 11:20 AM, which was twenty-five minutes late. Observation of the lunch tray line service in the kitchen on May 17, 2023, at 11:20 AM, revealed that staff were still setting up for the lunch tray line although the first cart was scheduled to arrive on the unit at this time. Further observation of the lunch tray line service revealed that dietary staff began serving the lunch meal at 11:35 AM. Interview with Resident 47 on May 17, 2023, at 11:45 AM, revealed that he enjoyed eating his breakfast in the main dining room, but the resident	F 0802		

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F 0802 SS=F	Continued from page 105 explained that the facility doesn't have enough dietary workers to consistently have the main dining room open for breakfast. The resident stated that there were times that the kitchen only had two dietary staff working. Interview with the dietary manager on May 17, 2023, at 12:00 PM, confirmed that the tray line began approximately fifteen minutes late due to dietary staff were unable to complete the dish room activities after breakfast to ensure enough meal service equipment for the lunch meal. The dietary manager stated that on some days, he had to perform kitchen duties, such as cooking because the dietary department was short staffed. The dietary manager also confirmed that the resident main dining room remained closed because there was no enough staff to serve the residents dining room meal service. Interview with the Nursing Home Administrator (NHA) on May 19, 2023, at 12:00 PM, confirmed that there were times that the staff in the dietary department was insufficient to maintain dining room	F 0802		

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F 0802 SS=F	Continued from page 106 meal service for resulted in delays in meal service. Refer F801 28 Pa. Code: 211.6 (c) Dietary services. 28 Pa. Code 201.18 (e)(1)(6) Management 28 Pa. Code 201.29 (j) Resident rights	F 0802		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 107 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Residents were not negatively affected by alleged deficient practice. The stainless-steel stand near the tray line will be cleaned. Temperature logs will be completed. Apple juice not dated in reach-in refrigerator will be discarded. Red stains and debris under dry-storage shelving will be removed. Walk in freezer produce will be dated. Thawed case of juice removed from cooler floor. Ice removed from freezer fan, ceiling and boxes. Maintenance will follow up with limescale buildup on clean dishware. Side door to dumpsters locked. Hot sauce will be discarded	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/09/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WAYNE WOODLANDS MANOR STATE LICENSE NUMBER: **065902**	**37 WOODLANDS DRIVE** **WAYMART, PA 18472**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 108	F 0812	from cook's refrigerator. Dietary Manager and staff will be educated on proper cleaning procedures, storage of supplies, labeling, temperature log documentation, infection control, changing of gloves, handwashing, covering of food on meal trays. Maintenance will be educated on preventative maintenance to prevent ice build up in freezer and keeping dumpster side doors locked. Administrator/designee will audit dietary department with regards to environmental conditions, cleanliness, sanitary conditions, and infection control measures weekly x4 then monthly x2. Results will be reviewed at monthly QAPI.	

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F 0812 SS=F	Continued from page 109 Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food).	F 0812		

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F 0812 SS=F	Continued from page 110 Review of a facility policy titled "Food Storage" that was reviewed by the facility on March 23, 2023, indicated that food will be stored in an area that is clean, dry, and free from contaminants. Food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. Food items will be stored on shelves and stored a minimum of 6-inches above the floor. All foods will be stored off the floor. Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. All freezer units will be kept clean and in food working condition at all times. The initial tour of the kitchen was conducted with the facility's Dietary Manager on May 16, 2023, at 9:03 AM, revealed unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness. The following dietary concerns were identified during tours of the blue building's kitchen area:	F 0812		

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F 0812 SS=F	Continued from page 111 A stainless-steel stand (near the tray line refrigerator) contained crumbs and debris on the surface and there were adaptive bowls and resident meal trays stored. The refrigerator temperature logs for May 2023 were not completed for the reach-in tray line refrigerator. Inside the reach-in, there was a bulk apple juice that was opened, but not dated. Inside of the dry-storage room, observation revealed that underneath the shelving there were several red stains and debris. Observation of the inside of the walk-in produce cooler, revealed that following items were not labeled or dated: 2-opened sliced American cheese bricks, a plastic storage container with 7 hardboiled eggs, 1/2 of a cook roast beef, 1/2 of a cooked turkey, bulk grated cheese, 1 block of butter, a bag of shredded cheddar cheese, a bag of mozzarella cheese. Additionally, there was a cooked ham and	F 0812		

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F 0812 SS=F	Continued from page 112 slices of ham in a pan that was not covered. Further observations inside of the produce cooler revealed that there was an opened and thawed case of 4-ounce juices that were placed directly on the cooler floor. Inside of the walk-in freezer, revealed that the freezer fan had an accumulation of ice. The blades of the fan were banging loudly against the housing and there was accumulation of ice on the ceiling and on boxes of frozen food stored in the freezer. Further observation inside of the walk-in freezer revealed that there were three beef rounds that had crystallization of ice on the outer packaging and an open bag of sausage crumbles that was opened and not labeled or dated. There was whipped topping that had ice crystal formation on the packaging. Inside of the cook's refrigerator observed that there was 3/4 of a store-bought lemon meringue pie that was not dated, but listed a resident's name. The	F 0812		

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F 0812 SS=F	Continued from page 113 dietary manager confirmed that the item was a resident's personal food and should not be stored in the main kitchen. Cleaned dishware was observed to have whitish color coating on the surfaces. The dietary manager stated at that time that it was limescale build-up. The side doors of two out of the three dumpsters were left opened with trash inside. An opened, undated bottle of hot sauce was observed in the cook's refrigerator. During observations of lunch tray line assembly on May 17, 2023, at 11:35 AM, the server was serving pizza with her gloved hands. Further observation the lunch tray line revealed that the server was touching other kitchen surfaces and did not change her gloves or perform hand hygiene and continued to serve the pizza wearing the same gloved hands.	F 0812		

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F 0812 SS=F	Continued from page 114 Follow-up kitchen observation that was conducted on May 18, 2023, at 11:25 AM, revealed that there was a rack with trays of iced spice cake being served with lunch plated on Styrofoam plates and were left uncovered. Observation on May 18, 2023, revealed nursing staff were passing the lunch meal trays in the hallways with the spice cake left uncovered and open to air. Interview with the Nursing Home Administrator on May 18, 2023, at 1:30 PM, confirmed that the dietary department was to be maintained and food should be stored and served in a sanitary manner. Refer F801 28 Pa. Code 211.6 (f) Dietary services. 28 Pa. Code 207.2(a) Administrator's responsibility.	F 0812		

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F 0842 SS=D		F 0842		

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F 0842 SS=D	Continued from page 116 483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility is unable to retroactively correct alleged deficient practice on Resident 26. To protect residents in similar situations, a look back of resident falls in the last two weeks will be conducted to assess for follow up documentation and assessment of resident. Licensed nurses will be educated on documentation post fall in clinical record, assessment of resident for pain and injury and timeliness of documentation. Director of Nursing will audit	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/09/2023**

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F 0842 SS=D	Continued from page 117 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842	documentation and assessment post fall in clinical record weekly x 4, then monthly x 2 to ensure completion. Results will be reviewed at monthly QAPI.	

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F 0842 SS=D	Continued from page 118 This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842 SS=D	Continued from page 119 Based on review of clinical records and select incident reports and staff interview, it was determined that the facility failed to maintain accurate and complete clinical records, according to professional standards of practice for one of 21 sampled residents (Resident 26). Findings include: According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient record to support the ability of the health care team to ensure informed decisions and high	F 0842		

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F 0842 SS=D	Continued from page 120 quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third parties. According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.11 (a) The register nurse assesses human responses and plans, implements and evaluates nursing care for individuals or families for whom the nurse is responsible. In carrying out this responsibility, the nurse performs all of following functions: (4) Carries out nursing care actions which promote, maintain, and restore the well-being of	F 0842		

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F 0842 SS=D	Continued from page 121 individuals (6)(b) The registered nurse is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and Subsection 21.18. (a)(5) document and maintain accurate records. According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.145. (a) The licensed practical nurse (LPN) is prepared to function as a member of a health-care team by exercising sound nursing judgement based on preparation, knowledge, skills, understanding and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place.	F 0842		

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F 0842 SS=D	Continued from page 122 A review of Resident 26's clinical record revealed that the resident was admitted to the facility on January 7, 2022, with diagnoses which included Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). A review of a facility incident report dated April 24, 2023, at 9:20 PM revealed the resident had an unwitnessed fall and was found lying on the floor on the left side of her bed. The resident had her left leg pulled up and out to her left side. When the leg was examined, it was noted to be slightly shortened and externally rotated. The resident at that time was complaining of hip pain. Further it was noted that the physician was made aware of the resident's fall the next day on April 25,	F 0842		

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F 0842 SS=D	Continued from page 123 2023, at 6:00 AM. A review of the resident's clinical record revealed a nursing note dated April 24, 2023, at 10:33 PM that indicated the resident had a fall at 9:20 PM. Nursing documented no further information regarding the resident's fall, signs of potential injury and pain in the resident's clinical record at that time. The facility staff failed to document a nursing assessment of the resident after the fall in the clinical record. An interview with the Nursing Home Administrator on May 19, at approximately 1:30 PM confirmed that the facility's nursing staff failed to timely document resident assessments in the clinical record.	F 0842		

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F 0842 SS=D	Continued from page 124 28 Pa. Code 211.5 (f)(h) Clinical records. 28 Pa. Code 211.12 (a)(c)(d)(1)(5) Nursing services.	F 0842		
F 0849 SS=D		F 0849		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0849 SS=D	Continued from page 125 483.70(o)(1)-(4) Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 0849	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Physician order will be obtained to include terminal illness for Hospice. Resident 65s care plan was updated and integrated to include Hospice. To protect residents in similar situations, care plans for residents on Hospice will be reviewed to ensure coordination of hospice services with facility services and physician orders will be reviewed to ensure terminal illness identified. Licensed nurses, RNAC and Social Services will be educated on coordination of hospice services on care plan and physician orders identifying terminal illness.	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/09/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395936	A. BLDG: 00 B. WING:	05/19/2023

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F 0849 SS=D	Continued from page 126 (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and	F 0849	Social Services /designee will audit Hospice care plans and physician orders for correct documentation weekly x4, then monthly x2. Results will be reviewed at monthly QAPI.	

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F 0849 SS=D	Continued from page 127 drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and	F 0849		

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F 0849 SS=D	Continued from page 128 capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any)	F 0849		

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F 0849 SS=D	Continued from page 129 orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by:	F 0849		

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F 0849 SS=D	Continued from page 130 Based on clinical record review and staff interview, it was determined facility failed to ensure physician orders for hospice care identified the terminal illness and failed to ensure coordination of Hospice services with facility services to meet each resident's needs for one out of 21 sampled residents (Resident 65). Findings include: Review of Resident 65's clinical record revealed that the resident was admitted to the facility September 29, 2022, with diagnoses to have included chronic obstructive pulmonary disease [(COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs with symptoms that include breathing difficulty, cough, mucus (sputum) production and wheezing], heart failure, and history of falls. Review of a significant change Minimum Data Set [(MDS - is part of a federally mandated process for clinical assessment of all residents in Medicare or	F 0849		

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F 0849 SS=D	Continued from page 131 Medicaid certified nursing homes that is conducted periodically to plan resident care] assessment dated January 21, 2022, revealed that section O0100. Special Treatments, Procedures, and Programs - K. Hospice care was coded "yes" indicating the resident received hospice care. A physician order dated dated March 28, 2023, at 4:00 PM, was noted to "admit to hospice." The physician's order did not identify the resident's terminal illness. Review of Resident 65's care plan failed revealed no evidence of an integrated care plan, developed between the facility and Hospice agency. Interview with the Director of Nursing (DON) on May 19, 2023, at 11:30 AM, confirmed that hospice care was not integrated into the resident's comprehensive person-centered care plan to demonstrate coordination of services between the Hospice agency and the facility to meet each resident's needs. The DON also verified that the	F 0849		

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F 0849 SS=D	Continued from page 132 physician order did not identify the terminal illness for admission to hospice care. . 28 Pa. Code 211.2 (a) Physician services 28 Pa. Code 211.11 (a)(b)(c)(d) Resident care plan 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services	F 0849		
F 0880 SS=F		F 0880		

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F 0880 SS=F	Continued from page 133 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Tracking Logs for January, February, March and April 2023 had previously been completed for those months, tracking infections for Skin/wound, UTI, Respiratory, GI, Eye, Ear, Nose, Blood, and other. Facility also tracked CVAD, Periph IV, Urinary Catheter, Chest Tubes, Surgical Drains, Dialysis, Feeding tubes, Trach tubes and other. Facility also tracked positive Covid infections and isolation precautions. Facility is unable to retroactively go back and identify detailed data that could be used to track infections and identify trends.	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/09/2023**

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F 0880 SS=F	Continued from page 134 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	To protect residents in similar situations, facility will implement Infection Control Log that will include detailed data that could be used to track infections and identify potential trends contained in the tracking data. Infection Control Preventionist will be educated in tracking of infections to include necessary details to conduct routine, ongoing, and systematic collection, analysis, interpretation and dissemination of surveillance data to identify infections. Director of Nursing/designee will conduct weekly audit x4, then monthly x2 to ensure monitoring of infections. Results will be reviewed at monthly QAPI.	

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F 0880 SS=F	Continued from page 135	F 0880		

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F 0880 SS=F	Continued from page 136 Based on observations, review of the facility's infection control tracking logs and policy and staff interviews it was determined that the facility failed to maintain a comprehensive program to monitor the development and spread of infections within the facility and plan preventative measures accordingly. Findings include: A review of the current facility policy for Infection Control Program Overview, adopted May 1, 2023, revealed that the infection prevention and control program is developed to address the facility-specific infection control needs and requirements identified in the facility assessment and the infection control risk assessment. The program is reviewed annually and updated as necessary. The	F 0880		

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F 0880 SS=F	Continued from page 137 program is based on accepted national infection prevention and control standards. A review of the facility's infection control data conducted during the survey of May 19, 2023, revealed that the facility's infection control tracking did not reflect evidence of a tracking system to monitor and investigate causes of infection and manner of spread. There was no documented evidence of a system, which enabled the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. A review of infection control data revealed the following infections were tracked as noted:	F 0880		

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F 0880 SS=F	Continued from page 138 August 2022: 7- urinary tract infection, 4-skin infections and 5- respiratory infections September 2022: 9- urinary tract infections, 3- skin infections, 1-respiratory infections October 2022: 2- Urinary tract infections, 1- Respiratory, 2- skin infections November 2022: 1-GI, 9-UTI, 4-skin, 5-respiratory, 1 eye infection December 2022: 7- Prophylactic antibiotics, 1-Flu B, 1-GI, 5-UTI, 5- skin, 3- respiratory infection January 2023: no evidence of monthly infection tracking logs	F 0880		

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F 0880 SS=F	Continued from page 139 February 2023: no evidence of monthly logs March 2023: no evidence of monthly logs April 2023: no evidence of monthly logs May 2023: 3-skin, 1-UTI, 2-URI, 4-"Misc infections", 3-skin The facility's infection control log revealed no documented evidence of detailed data collection that could be used by the facility to track these infections and to identify any potential trends contained in the tracking data. The data did not include resident room location or the infectious organism. There was no documented evidence at the time of the survey that based on the available tracking data that the facility had identified any	F 0880		

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F 0880 SS=F	Continued from page 140 possible trends in order to implement specific interventions to prevent the spread of any of the infections. There was no documentation by the facility of the any of the infection start dates, resolution date, symptoms, available or complete culture information for any of the infections noted in the facility's monthly infection control tracking logs and the treatments required, if any. It could not be determined if any of the noted infections required isolation protocols to be implemented. There was no indication that the limited data that was compiled was then evaluated to determine what could be done to prevent the spread or recurrence of infection.	F 0880		

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F 0880 SS=F	Continued from page 141 During an interview conducted on May 18, 2023, at approximately 11 AM the Infection Control Preventionist confirmed that the facility's infection control tracking was incomplete and failed to include the necessary details to conduct routine, ongoing, and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections (i.e., HAI and community-acquired), infection risks, communicable disease outbreaks, and to maintain or improve resident health status and to track staff for adherence to infection control policies and procedures and the potential need to for corrective action. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395936	A. BLDG: __00_____ B. WING: _____	05/19/2023

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F 0880 SS=F	Continued from page 142 28 Pa. Code 211.10 (a)(d) Resident care policies	F 0880		

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F 0880 SS=F	Continued from page 143	F 0880		

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F 0880 SS=F	Continued from page 144	F 0880		
F 0881 SS=D		F 0881		

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F 0881 SS=D	Continued from page 145 483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by:	F 0881	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. MD discontinued Nitrofur Mac medication on 6/12/2023. To protect residents in similar situations, residents who are on a daily dose of antibiotic for urinary tract infection will be assessed for individual specific clinical rationale as to the benefits to the resident to support the continued use. Licensed nurses and facility Physicians will be educated on the specific clinical rationale for ongoing daily use of antibiotic for urinary tract infection. Director of Nursing/designee will	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/13/2023**

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F 0881 SS=D	Continued from page 146	F 0881	audit residents on continued use of antibiotic therapy for urinary tract infection for individual specific clinical rationale weekly x4, then monthly x2. Results will be reviewed at monthly QAPI.	

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F 0881 SS=D	Continued from page 147 Based on a review of clinical records and the facility's infection control policies and staff interview it was determined that the facility failed to maintain an antibiotic stewardship program that includes a system to effectively monitor antibiotic usage as evidenced by one of 21 sampled residents (Resident 33). Findings include: A review of the facility policy for Antibiotic Stewardship, dated as reviewed May 1, 2023, revealed that, culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities. Medical criteria and standardized definitions of infections are used to help recognize and manage infections. Antibiotic usage is evaluated and practioners are provided feedback on	F 0881		

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F 0881 SS=D	Continued from page 148 reviews. A review of Resident 33's clinical record revealed a physician order dated November 18, 2020 for Nitrofur Mac cap (an antibiotic medication) 50 mg, take one capsule by mouth at bedtime for urinary tract infection. A review of the resident's medication administration record for the months of November 2020, through the present date revealed that the resident received a daily dose of the antibiotic. A review of a Pharmacy to Physician medication assessment recommendation dated April 17, 2023 revealed that the pharmacist identified and reported to the physician that Resident 33 is currently receiving Nitrofurantoin 50 mg, by mouth,	F 0881		

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F 0881 SS=D	Continued from page 149 daily at bedtime for Urinary tract infection prophylaxis (action taken to prevent disease, especially by specified means or against a specified disease). Request your consideration for discontinuing this medication. If you feel that its use is appropriate, request documentation of your risk vs benefit assessment on this form. The physician response was noted as "Supervised usage of antibiotics is noted. Benefits outweighs risks. No change in medication." The physician included no resident specific rationale of the benefits to continue daily prophylactic antibiotic administration to Resident 33. There was no evidence at the time of the	F 0881		

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F 0881 SS=D	Continued from page 150 survey of a functioning antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use to prevent unnecessary antibiotic use, including Resident 33. During an interview May 1, 2023 at 1 P.M., the Director of Nursing confirmed that the facility's antibiotic stewardship program did not identify and address Resident 33's continued use of the daily antibiotic without adequate documented supporting clinical evaluation and rationale from the physician. Refer F757 28 Pa. Code 211.12 (c)(3)(5) Nursing services	F 0881		

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F 0881 SS=D	Continued from page 151 28 Pa. Code 211.2(a) Physicians services 28 Pa. Code 211.10 (a) Resident Care Policies	F 0881		

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F 0881 SS=D	Continued from page 152	F 0881		
F 0886 SS=E		F 0886		

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F 0886 SS=E	Continued from page 153 483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.	F 0886	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Facility is unable to retroactively correct deficient practice on Resident's 56, 60 and 43. Resident's 56, 60 and 43 remain at facility and were not negatively affected. Facility unable to go back and conduct Covid testing on staff. To protect residents in similar situations, facility will follow CMS directives on Covid-19 testing requirements regardless of vaccination status. Residents and staff with signs and symptoms of Covid-19 will be tested timely. Facility staff will be educated to	Completion Date: 07/11/2023 Status: APPROVED Date: 06/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0886 SS=E	Continued from page 154 §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by:	F 0886	notify Infection Control Preventionist, Nursing Supervisor DON or ADON if they are aware of a resident(s) or staff exhibiting Covid-19 symptoms and the need to promptly Covid test. Infection Control Preventionist/designee will monitor 24 hour Nursing Report weekly x4 then monthly x2 for symptomatic residents. Results will be reported at monthly QAPI.	

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F 0886 SS=E	Continued from page 155	F 0886		

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F 0886 SS=E	Continued from page 156 Based on a review of CMS directives and clinical records, and staff interviews it was determined that the facility failed to accurately conduct staff COVID-19 testing for three or 3 symptomatic residents (Resident 56, 60, and 43). Findings included: According to the Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Survey & Certification Group QSO-Memo - 20-38-NH last revised September 23, 2022, revealed residents regardless of vaccination status with signs or symptoms of COVID-19 must be tested. A review of Resident 56's clinical record revealed on February 14, 2023, at 2:17 PM the resident was noted with a harsh	F 0886		

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F 0886 SS=E	Continued from page 157 nonproductive cough. On February 15, 2023, at 1:18 AM it was documented that the resident continued with a harsh nonproductive cough. At at 2:46 PM the resident still had a harsh nonproductive cough and was lethargic. At 10:53 PM the harsh nonproductive cough continued, and the resident was lethargic. A review of nursing notes on February 16, 2023, at 12:04 PM revealed that the resident continued with a harsh nonproductive cough and was lethargic. At 2:17 PM the resident was noted to still have the harsh nonproductive cough and lethargy. No documentation was found in the resident's clinical record that the resident	F 0886		

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F 0886 SS=E	Continued from page 158 was tested for COVID-19 despite exhibiting signs and symptoms. Review of Resident 43's nurse's notes dated February 17, 2023, at 11:46 AM, indicated that the resident had complaints of not feeling like himself and was shaky with transfers. Also, it was noted that the resident had an occasional loose non-productive cough and had 3 bouts of loose stools. Nurse's notes at 11:02 PM on February 17, 2023, indicated that the resident had an occasional loose non-productive cough and was incontinent of loose stool 3 times during the shift. On February 22, 2023, at 1:43 PM, Resident 43 cold signs and symptoms continued, and lung sounds presented	F 0886		

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F 0886 SS=E	Continued from page 159 with expiratory wheeze, and an occasional loose nonproductive cough. Resident 43's clinical record failed to reveal documented evidence that the resident had been tested for COVID-19 despite exhibiting signs and symptoms. A review of Resident 60's nursing notes dated February 20, 2023, at 10:56 AM, indicated the resident woke up that morning with a harsh nonproductive cough. The resident was noted to be covered in sweat and was weak. The resident's lung sounds had noted wheezing. The resident's oxygen level at that time was 78% (normal is 90 to 100) on room air. A review of nursing notes dated February 20, 2023, at 1:28 PM revealed the	F 0886		

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F 0886 SS=E	Continued from page 160 resident's oxygen level remained low ranging between 68% to 74%. The resident stated at that time she did not feel good. No documentation was found in the resident's clinical record that the resident was tested for COVID-19 despite exhibiting signs and symptoms. Interview with Director of Nursing on May 19, 2023, at approximately 1:30 PM confirmed the residents should have been tested for COVID-19 based on their signs and symptoms, but were not tested. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(5) Nursing	F 0886		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0886 SS=E	Continued from page 161 services	F 0886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395936	A. BLDG: 00 B. WING:	05/19/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WAYNE WOODLANDS MANOR STATE LICENSE NUMBER: **065902**	**37 WOODLANDS DRIVE** **WAYMART, PA 18472**

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P 0555	§ 201.20(c) Staff development. (c) There shall be at least annual inservice training which includes at least infection prevention and control, fire prevention and safety, accident prevention, disaster preparedness, resident confidential information, resident psychosocial needs, restorative nursing techniques and resident rights, including personal property rights, privacy, preservation of dignity and the prevention and reporting of resident abuse. This REGULATION is not met as evidenced by:	P 0555	Preparation and/or constitution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This deficiency did not negatively affect any resident. Facility staff will be educated on Restorative Nursing annual mandatory in-service to include each Department. Department Heads will be educated on annual mandatory in-service training to include each department. Human Resources/designee will audit mandatory education sign in sheets to ensure all employees have been educated x12. Results will be reviewed at monthly QAPI.	Completion Date: **07/11/2023** Status: **APPROVED** Date: **06/12/2023**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395936	A. BLDG: 00 B. WING:	05/19/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WAYNE WOODLANDS MANOR STATE LICENSE NUMBER: **065902**	**37 WOODLANDS DRIVE** **WAYMART, PA 18472**

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P 0555	Continued from page 1 Based on review of annual in-service trainings and staff interview, it was determined that the facility failed to provide annual mandatory in-service education to all employees. Findings include: Review of the facility's mandatory in-service logs, revealed no documented evidence that all staff members, disciplines that included administration, nursing, housekeeping, maintenance, dietary and activities, received annual mandatory in-service training in the area of restorative nursing. Interview with the Nursing Home Administrator on May 19, 2023, at approximately 1:30 PM, confirmed that the facility failed to provide all employees	P 0555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395936	A. BLDG: __00_____ B. WING: _____	05/19/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
WAYNE WOODLANDS MANOR STATE LICENSE NUMBER: **065902**	**37 WOODLANDS DRIVE WAYMART, PA 18472**

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P 0555	Continued from page 2 annual mandatory in-service educations.	P 0555		

Certified End Page

WAYNE WOODLANDS MANOR

STATE LICENSE NUMBER: 065902

SURVEY EXIT DATE: 05/19/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY